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OFFICIAL MEMORANDUM

July 16, 2007

TO: **All Interested Parties**

FROM: **DMH Executive Team**

SUBJECT: **Initiation of the Missouri Department of Mental Health's State Fiscal Year 2009 Budget Development Cycle**

This memo initiates the Department of Mental Health's (DMH) State Fiscal Year (SFY) 2009 budget development cycle, offering information for parties interested in recommending budget items or suggestions for DMH budget priorities. It includes seven sections:

1. ***SFY 2008 budget highlights;***
2. ***The "required" SFY 2009 budget items;***
3. ***A brief SFY 2009 economic and political environmental scan;***
4. ***Key Missouri mental health issues in SFY 2009;***
5. ***DMH Executive Team SFY 2009 priority areas;***
6. ***The DMH Director's SFY 2009 recommended DMH budget ceiling; and***
7. ***SFY 2009 budget submission protocols and timeframe.***

SFY 2008 BUDGET HIGHLIGHTS

With strong support from Governor Matt Blunt and legislative leaders, DMH experienced a 9.8% increase in all funds over FY 2007 budget. In addition to the core budget, FY 2008 appropriations include:

- $8.2 million for a 3% pay increase for state employees;
- $19.2 million for a community provider cost-of-living adjustment;
- $1.9 million to allow an increase in pay for direct care workers;
- $788,000 to address staff training and development;
- $4.8 million for the Ticket-to-Work Health Assurance Program;
- $2 million to address anticipated Medicaid caseload growth;
- $1.5 million increase for DMH operations (food, medical care, medications etc);
- $1.0 million for treatment of adolescents with co-occurring addiction/mental illness;

- $1.5 million for the Missouri Sexual Offender Treatment Center;
- $3.6 million for Fulton State Hospital for population increases;
- $750,000 for a collaborative program between CMHCs and FQHCs;
- $4.8 million for Assertive Community Treatment Teams;
- $2.4 million for school-based mental health services;
- $15.8 million to address the wait list for the developmentally disabled;
- $3.9 million for autism treatment and diagnosis;
- $1.7 million to ensure staffing standards at the habilitation centers are met statewide;
- $600,000 for readiness assessment for accreditation of MRDD facilities/programs; and
- $3.7 million for additional service coordination for persons with DD via community partnerships with SB40s and Affiliated Community Service Providers (ACSP).

FY 2008 Appropriation	$ 590,404,867	8,112.66 FTE	GR
	482,058,417	676.56 FTE	Fed
	44,358,575	37.00 FTE	Other
	$1,116,821,859	**8,826.22 FTE**	**TOTAL**

COST-TO-CONTINUE AND COLA SFY 09 BUDGET ITEMS

- **Cost-to-Continue Items Passed in SFY '08:**
  - ***Missouri Sexual Offender Treatment Center Expansion*** -- $384,758 – 10.85 FTE/GR-- partial year funding was appropriated in FY 2008 to open a new 17-bed treatment unit. Additional funding is needed in FY 2009 to provide full-year funding to staff and operate this unit.

  - ***CMHC & FQHC Collaboration*** - $750,000 GR -- six-months funding was appropriated in FY 2008 to allow the CMHCs and FQHCs to develop pilot sites of integrated preventive healthcare and health management, including mental illness and physical care services to target the uninsured. Additional funding is needed in FY 2009 to provide full-year funding.

  - ***MO Medicaid Mental Health Partnership Technology Initiative GR Pick-up*** -- $1,250,000 GR -- one-time funding from the Healthcare Technology Fund was appropriated in FY 2008 to support this initiative. In FY 2009, the Department will request on-going GR. This initiative includes Behavior Pharmacy Management which addresses inappropriate psychotropic prescribing practices, Treatment Adherence Program which addresses patient medication adherence, and Integrated Care Coordination which utilizes health information technology to identify high risk patients and provide specialized care coordination.

- **Projected DMH Operations COLA Increases**:
  - Increased Food Costs -- $200,000 est. GR (3%) – DMH inpatient facilities continue to face growing costs for food and food supplies.

  - Increased Medical Care Costs -- $306,000 est. GR (4%) -- Consumers in state facilities are facing growing costs for medical care and treatment.

- Increased Costs for Medications -- $1.2M est. GR (10.5%) -- The Department continues to face growing costs for medications.

- Medicare Part B Premium Increases -- $33,000 est. GR (11.6%) – Payment of these premiums maintain Medicare insurance for eligible forensic clients allowing Medicare to pick up a major portion of client medical expenses. *(Note: initial estimate assumes annual rate increase of 11.6%, the average since 2002.)*

- **Projected State Employee Salary Increases --**The Personnel Advisory Board's preliminary recommendations for FY 2009 includes a 3.7% General Structure Adjustment (also known as a COLA). The FY 2009 DMH budget request will not include funding for an across-the-board employee COLA. That will be addressed for all state employees during the Governor's budgeting cycle. Estimated GR costs of a 3.7% increase for DMH employees is $9.7 million.

- **Projected Pay Range Repositioning –** DMH has submitted a proposal to OA Division of Personnel to reposition 29 clinical and direct care classifications and is awaiting input from the Personnel Advisory Board (PAB). The estimated cost is $2.5 million.

- **Provider Cost-of-Living Adjustment** – $12.7 million GR; $12.9 million FED; $770,000 Other funds for a total of $26.4 million est. (3.7%) -- A cost-of-living adjustment will allow the community treatment and residential care providers to keep pace with state employee salaries and increases in fuel, utilities, food, transportation costs, etc. *(Note: request is consistent with the SFY'09 preliminary state employee pay plan recommendation by the PAB.)*

- **Medicaid Caseload Growth** -- $759,439 GR; $1,250,723 FED; total -- $2,010,162 *(represents FY 2008 appropriation; awaiting FY 2009 estimates from DSS) to* offset increased costs associated with the projected Medicaid caseload growth.

- **Medicaid Match Rate Adjustment** -- The federal share of the blended Federal Financial Participation (FFP) rate is adjusted annually and the budget increased or decreased in the State share (GR) accordingly. Once this data is available, the Department will take the appropriate FY 2009 budget action.

SFY 2009 ENVIRONMENTAL SCAN

SFY 2009 State Revenue Projections: State Fiscal Year 2007 ended with 5.2% general revenue growth as compared to the 4.0% forecasted. Revenue growth in Fiscal Year 2008 is expected to be near the estimate of 3.8%. ***Fiscal Year 2009 consensus revenue projections are not available at this time.*** Until such projections are made, DMH will assume revenue growth between 3.5 to 4.0% for SFY 2009.

Extraordinary Pressures on the State's Budget: At this point there are no foreseeable extraordinary pressures on the state's budget anticipated to consume revenue growth and depress the opportunity for modest program expansion.

State Employee FTE Limits: Governor Blunt is committed to holding the total state Full Time Equivalent (FTE) positions to 60,000. Total state FTEs are currently above 59,950. The new women's prison in Chillicothe, which opens soon, will require an additional 360 FTE. SFY '09 budget proposals that include significant growth in FTE are unlikely to be favorably received.

Missouri's SFY 2009 Political Environment: The 2008 federal and state elections will predominant Missouri politics, particularly the Governor's race and key legislative races. At the DMH level, consumer safety and Bellefontaine Habilitation Center are likely to continue as key topics in the political arena. Other mental health issues with political sensitivity during the SFY 09 discussions include:

- The Missouri Sexual Offender Treatment Center program in Farmington,
- Converting state operated psychiatric acute facilities and MRDD case management to local community control.
- Proposed name change of MRDD to the Division of Developmental Disabilities.

KEY MENTAL HEALTH ISSUES RELEVANT TO SFY '09 BUDGET DEVELOPMENT

1. Missourians' Inability to Access DMH Services:

- Even with the resources available through the SFY 2008 budget, 3,886 eligible individuals will remain on the MRDD waiting list for in-home or residential services.

- ADA's contracted treatment providers will serve only about 10% of the roughly 400,000 Missourians in need of help for substance abuse problems, even though research shows that if people seeking treatment do not get it within 48 hours, they withdraw and are too often later found in emergency rooms, jails, or psychiatric facilities.

- DMH does not have funding to cover Missourians without health insurance or Medicaid eligibility when they seek help for mental health problems. Approximately 800,000 are without insurance or Medicaid eligibility.

- Multiple cities in Missouri have chronically homeless individuals in need of mental health, substance abuse and housing services on any given day.

- Most of Missouri's state psychiatric facilities will operate at over 100% capacity each day of SFY 2008. State hospitals are frequently on diversion (meaning that they refuse to take additional patients) due to being overcapacity.

- State psychiatric acute care emergency rooms routinely turn people away, including police officers bringing individuals in acute psychiatric crisis seeking help for them in lieu of arrest and incarceration.

2. System Quality of Care Issues:

Media coverage and statewide hearings conducted by the Mental Health Commission and Lt. Governor Peter Kinder's Statewide Mental Health Task Force highlighted serious quality

deficiencies resulting in abuse and neglect in Missouri's DMH's service system, including:

- DMH's inability to recruit, train and retain direct care and key clinical staff in both CPS and MRDD facilities. Examples: Marshall Habilitation Center routinely operates with at least 60 direct care staffing vacancies, exhausting available staff through mandatory overtime. The annual turnover rate for psychiatrists and nurses at CPS facilities exceeds 30%. These phenomena are occurring in many other DMH facilities.

- A similar crisis is occurring in DMH contracted community provider agencies, whose starting pay for direct care staff is between $7-8 per hour for direct care staff. (By contrast, DMH pays $10 per hour and still cannot recruit enough direct care staff.)

- MRDD has statewide inconsistencies in eligibility determination, service planning, waiting list criteria, case management and treatment services.

- CPS housing services are inadequate, relying heavily on large, under-funded residential care facilities.

- Hundreds of individuals who are seriously mentally ill or alcohol and/or drug dependent are also chronically homeless.

- MRDD central administration does not have the clinical leadership necessary to assure high quality care in its state operated and community placement programs forcing MRDD to hire expensive consultant companies to perform basic clinical quality control functions.

3. Need for Better Mental Health and Medical Service Interface

According to recent research involving eight states, including Missouri, persons with serious mental illnesses (SMI), on average, will die 25 years earlier than the average American. The majority will die from the same diseases that will also kill most of the rest of us, including complications from diabetes, cardiovascular diseases, COPD, etc. But DMH consumers will die much earlier; many of the reasons are obvious, including poverty, poor nutrition, lack of exercise, and the side effects of powerful psychotropic medications. Frequently, they will die earlier because of uncoordinated medical care. As Dr. Joe Parks, DMH Medical Director, likes to say, "We probably can't get too excited about eliminating psychiatric symptoms or improving a patient's behavioral functioning by a few points if s/he going to die on us at age 50 from a medical disease we could have treated!" DMH can no longer be content to focus solely on a psychiatric illness without attending to the individual's broader physical health needs. This is equally true of the consumers in ADA and MRDD.

4. Inability of DMH Facilities Efforts to Move Residents to Community Placement:

- Seven of ten residents in state psychiatric facilities are "forensic" patients, either determined incompetent to stand trial for a committed crime, determined not guilty by reason of insanity, or deemed a sexual predator in need of treatment after lengthy stays in a Missouri Corrections facility. Once DMH has treated these patients and deems them ready to leave an institutional facility, their right to community placement is at the committing court's or local prosecutor's discretion. Judges are reluctant to release such patients. As a result, DMH

psychiatric inpatient facilities are backing up, admitting far more commitments than discharges. This, in turn, clogs acute care facilities, which must hold patients longer who are awaiting admission into state long-term psychiatric care. This system "constipation" forces state facilities to operate beyond 100% of capacity for long periods of time, exhausting staff, causing staff overtime and high turnover rates, and inevitably increasing the risk of staff injuries and patient abuse and neglect.

- A similar problem is now increasingly occurring in state-operated MRDD habilitation centers from forensic referrals, the admission of a younger population with borderline intellectual functioning and severe behaviors or sexual deviancy, and refusal of guardians to allow community placement.

5. Need to Link Critical Mental Health Services to other Human Service Programs

- Approximately 9,700 children are in Children's Division custody. Over 35% been placed in custody because of substance abuse (2,900) or alcohol abuse (850) by the parent(s), and some for both. Most children removed believed that they did something wrong that cause their separation from family. All need mental health screening and counseling, while their parents need comprehensive assessment and intensive substance abuse treatment.

- Despite tragedies such as those at Columbine High School and other schools across America, only nine Missouri school districts have qualified mental health professionals serving in a formal school-based mental health program. Seven additional Missouri school districts have written grants for school based mental health services.

- Over 15% of all incarcerated inmates in Missouri Corrections facilities have a diagnosed serious mental illness such as schizophrenia, bi-polar disorder, or major depression, not counting persons with substance abuse problems; 75% of these individuals will re-offend and return to Corrections within five years of release. DMH does not yet have coordinated discharge planning and community treatment services available to these individuals.

- Over 75% of incarcerated inmates have substance abuse problems. One in four known substance abusers that do not get treatment will return to prison within the first year of release, while those who get treatment in prison with continuing care in the community return at a rate of less than 5%.

- One in every 13 admissions to Missouri hospitals are alcohol or other drug related, and over half of those were admitted through emergency rooms. Furthermore, about 22% of psychiatric acute care admissions are persons with substance use disorders. Missouri has only three modified medical detoxification centers that are capable of providing alternatives to hospitalization.

- Over 50% of all incarcerated individuals in the Kansas City Municipal Jail have a serious mental illness, a phenomenon increasingly typical in local jails. Many are homeless. DMH does not provide treatment services, discharge planning, housing supports, or community treatment for these individuals.

- The Department of Health and Senior Services has noted increasing numbers of eldercare hotline referrals associated with mental disorders or substance abuse problems. DMH and DHSS do not yet have mechanisms to coordinate services needed by these referrals.

6. **Special Populations With Unmet Mental Health Needs:** The Mental Health Commission, MH Transformation Groups and the DMH Leadership Team have identified four underserved populations with significant unmet mental health needs:

- ***Missouri Elders*** with mental health problems like depression, dementia, and substance abuse, which often exacerbate with age, personal loss and complicated medical conditions. Missouri elders comprise 13.5% (800,000) of the state's population and will grow to 20% by 2030.

- ***Deaf or Severely Hearing Impaired Children and Adults*** with mental health disorders. 2% of Missourian's are culturally deaf; 1,700 deaf adults have severe mental illness; 500-1,000 deaf children have severe emotional disturbances. DMH has not adequately addressed mental health needs of people who are deaf/severely hearing impaired.

- ***Missouri Military Personnel Involved in the Iraq and Afghanistan War:*** According to information from a study of 205,097 veterans undertaken by the VA and Duke University, 35.7% (73,157) of veterans reported mental health issues. For the 22,000 Missouri troops deployed to Iraq and Afghanistan, this would equate to 7,900 troops who would need mental health services upon de-activation. The Veterans Administration and state mental health agencies have not yet developed interface mechanisms to assure coordination of federal and state services.

- ***Non-English-speaking Immigrants and Evolving Ethnic Communities:*** Missouri has experienced in-migration of new ethnic populations, including Hispanics, Bosnians/ Croatians/Serbians, Vietnamese, Arabic, etc. DMH must develop appropriate interpreter services, train clinicians for cultural awareness and recruit mental health professionals and natural support agencies and individuals from ethnic population ranks.

7. **DMH Statutory Mandate to Prevent Mental Disorders, Developmental Disabilities and Other Alcohol and Drug Abuse in Missouri**

Missouri DMH is not adequately addressing one of its three statutory missions, that of preventing mental disorders, developmental disabilities and substance abuse (Chapter 630.020 RSMO). There is a perception that prevention is vague and unaccountable, but there examples of specific, measurable prevention objectives that can achieve good outcomes.

- Some developmental disabilities (i.e., fetal alcohol syndrome, spina bifida) can be prevented in children through good prenatal care during pregnancy and by increasing the awareness of the importance of not smoking or using alcohol and other drugs during pregnancy.

- Research shows that children of alcoholic parents are far more likely to become involved in alcohol and drug abuse. We may be able prevent cross-generational substance abuse through preventive education and support for the children of substance abusers.

- Mental health services based directly in schools have been demonstrated to significantly reduce school behavior problems and increase attendance, and could be a factor in reducing the likelihood of the next Columbine or Virginia Tech.

- Men over the age of 65 have the highest rate of completed suicide of any age group. Initiatives to provide mental health screenings for seniors and implement treatment at early stages of depression have been found to reduce suicide attempts and completions.

- An early childhood program pioneered in Baltimore has been found to reduce classroom aggression and disruptive behaviors. Follow up with young adults who received the intervention as children has found reduced substance abuse and dependency disorders, smoking and antisocial personality disorders.

- A school-based primary prevention program developed in Norway reduced direct and indirect bullying (both in and out of school) by 50%, reduced other antisocial behaviors such as vandalism, theft, substance abuse, and demonstrated improvements in the classroom, interpersonal relationships, schoolwork and satisfaction with life.

- Many Missouri children face stressors associated with marital disruption that increase the risk for psychological problems. Children of divorce constitute a majority of all referrals to mental health services (Zill et al, 1990). Intervention programs have demonstrated improved outcomes in adjustment and reduced risk for these children.

- Suicide is still a leading cause of death for adults and children with mental disorders. Suicide prevention programs and early crisis intervention are proven prevention tools.

8. Improving Public Understanding and Attitudes About Mental Health

DMH's third statutory mission is to improve the public's understanding and attitudes toward mental disorders, developmental disabilities and alcohol and drug abuse (Chapter 630.020 RSMO). DMH has not requested funding for this mandate nor mounted a consistent stigma reduction effort in recent years.

DMH EXECUTIVE TEAM SFY 2009 New Decision PRIORITY AREAS

Along with the "required" budget items cited earlier, the DMH Executive Team has identified the following priority areas for SFY 2009:

- Autism Services;
- School-based Mental Health Services;
- Substance abuse services to families with children in DSS custody;
- Services that integrate medical care, pharmacy and behavioral treatment;
- Implementation of Electronic Medical Records for DMH facilities and programs;
- Services that focus on prevention or early intervention of psychiatric crises;
- Services that allow safe placement of long-term care patients into community settings;

- Funding and strategies to retain and support direct care staff, both in community residential settings and in state-operated facility programs;
- Funding/strategies to retain and support key clinical positions in community and DMH facility programs, including psychiatrists, psychologists, therapists and nurses;
- Offender reentry programs for co-occurring MI/SA inmates leaving Corrections;
- Specialized services for individuals who are deaf and severely hearing impaired;
- Mental health services for children and their families involved in abuse and neglect situations;
- Creation of a DMH training academy of the scope and quality similar to the academies at the Department of Corrections and the Highway Patrol;
- Funding to support direct care staff training costs for the College of Direct Support program.
- Specialized treatment and housing supports for homeless, mentally ill and substance abusing individuals who are "frequent flyers" e.g. who repeatedly frequent emergency rooms and psychiatric inpatient programs;
- Funding to provide services to eligible persons with developmental disabilities on the MRDD waiting list, and individuals with mental health problems who are newly Medicaid eligible;
- Funding to provide more alcohol and drug treatment on demand;
- Funding to promote accreditation of MRDD, CPS and ADA community providers and MRDD state-operated habilitation centers;
- Funding for specialized mental health eldercare services;
- Funding to promote employment opportunities for DMH consumers;
- Funding for the prevention of mental diseases, DD and substance abuse; and
- Funding to increase public understanding and attitudes about persons with mental disorders, developmental disabilities and alcohol and drug abuse.

DMH EXECUTIVE TEAM SFY 2009 "PROGRAM REDIRECT" PRIORITIES

In addition to seeking new funding for DMH priorities, the Executive Team is committed to redirecting funding in existing programs when appropriate. DMH is considering redirect initiatives in the following programs:

The Missouri Sexual Offender Treatment Program (MOSOTC): MOSOTC provides treatment for sexual predators that have completed their sentences in the Missouri Department of Corrections and are still deemed a risk to society. Two categories of individuals are housed at MOSOTC. The first are detainees awaiting a court decision regarding whether they should be committed to DMH for treatment of their sexually deviant behaviors. The second are individuals for whom court commitments have already been issued. DMH is considering paying county jails to house detainees awaiting court commitment proceedings. For committed individuals who are elderly or medically fragile, but not yet determined appropriate for community placement, DMH is considering creating a special treatment unit at the state-operated Southeast Missouri Mental Health Center (formerly called Farmington State Hospital) for more appropriate treatment.

Conversion of State Operated Acute Psychiatric Centers to Local Community Control: Missouri operates acute psychiatric inpatient beds at Western Missouri Mental Health Center, Metropolitan Psychiatric Center, Southeast Missouri Mental Health Center, and Mid-Missouri Mental Health Center. All these programs are federally designated as *"Institutions for Mental*

Disease" (IMDs). Under Federal IMD status, Missouri receives only limited funding from the Medicaid program. DMH has determined that, through a complex process that could remove the IMD status for state acute psychiatric centers, it could generate up to $56 million in new funding for crisis diversion, community-based, and new inpatient mental health services. This would, however, require that state centers become part of a larger community health care system, or that the state operate stand-alone acute care centers at 16 beds or less per facility. A critical issue to be addressed if DMH moves forward with this initiative is to create mechanisms that assure that at least the same number of psychiatric beds are available in the long term future for the same types of patients now served in the state facilities. A second key consideration is the acceptance of key stakeholders currently served by state acute care centers. Viable answers to both issues must be found if DMH is to proceed with this transformation.

Conversion of State Operated MRDD Case Management Functions to Local Community Control: MRDD is the only DMH division that still provides case management services using approximately 484 state workers. Medicaid reimbursement mechanisms may make it possible to perform the case management function more effectively through community providers. This may generate more reimbursement per case manager, thus allowing more consumers to be served and still reducing the caseload-to-client ratios which are far too high in some areas of the state. Community providers who assume case management responsibility would have to replace that portion of funding currently generated by state case managers now used for treatment services.

DIRECTOR'S UPPER LIMIT ON SFY 2009 TOTAL NEW GR REQUEST

Excluding Federal and other funds or redirected GR funds, the DMH director recommends a total DMH GR budget request for SFY '09 up to 8% of the department's total budget.

BUDGET RECOMMENDATION PROTOCOLS AND TIMELINES

Those interested in making a budget recommendation should consider the information in this document in accordance with the following protocols and timeframes.

Key Budget Timelines:

- August 9 — Presentation of the FY 2009 "DRAFT" Budget Request to the Mental Health Commission.
- August through. September — Conduct detailed budget analysis, prepare reports and budget forms related to core and new decision items.
- September 13 — Final review and approval of the FY 2009 Budget Request by the Mental Health Commission, including review and approval of decision item priority rankings.
- October 1 — FY 2009 DMH Budget Request to be submitted to the Office of Administration, Division of Budget & Planning.

Public Input:
We invite you to submit suggestions or feedback to the following individuals for new budget items. Input from consumers, families and providers are invaluable as the Department plans for the future. **Please send your comments to the appropriate individual by July 30, 2007, as follows:**

FOR BUDGET ITEMS RELATED TO:	CONTACT
Department-wide	**Keith Schafer, Director** **Department of Mental Health** **PO Box 687, 1706 E. Elm** **Jefferson City, MO 65102** **Keith.Schafer@dmh.mo.gov**
Division of Alcohol and Drug Abuse (ADA)	**Mark Stringer, Director** **Division of ADA** **Department of Mental Health** **PO Box 687, 1706 E. Elm** **Jefferson City, MO 65102** **Mark.Stringer@dmh.mo.gov**
Division of Comprehensive Psychiatric Services (CPS)	**Joe Parks, Director** **Division of CPS** **Department of Mental Health** **PO Box 687, 1706 E. Elm** **Jefferson City, MO 65102** **Joe.Parks@dmh.mo.gov**
Division of Mental Retardation & Developmental Disabilities (MRDD)	**Bernard Simons, Director** **Division of MRDD** **Department of Mental Health** **PO Box 687, 1706 E. Elm** **Jefferson City, MO 65102** **Bernard.Simons@dmh.mo.gov**